Required Registration Form
Regina Early Childhood Center
2140 Rochester Avenue, Iowa City, IA 52245

Parental Emergency Medical Consent

Child Full Legal Name: _____ **Date of Birth:** _____

This form allows parents and guardians to authorize the provision of emergency treatment for the above named child who becomes ill or injured while under program authority when parents or guardians cannot be reached.

In the event that reasonable attempts to contact me at (Phone #): _____ or (Phone #): _____ have been unsuccessful, I hereby give consent for the administration of any treatment deemed necessary by:

Physician: _____ at (Phone #): _____ or
Dentist: _____ at (Phone #): _____, or in the event that the designated practitioners are not available, then by another licensed physician or dentist; and the transfer of the child to (Preferred Hospital): ☐ Mercy ☐ University of Iowa ☐ Other: _____.

Parents/Guardians/Custodians with Whom the Child Resides:

Name: _____

Relationship to Child: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Department: _____

Work Phone: _____ Work Hours: _____

Name: _____

Relationship to Child: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Department: _____

Work Phone: _____ Work Hours: _____

Parent/Guardian Initials:

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2140 Rochester Avenue, Iowa City, IA 52245

Parental Emergency Medical Consent (ctd.)

Emergency Contacts (in case of emergency if parents are unavailable):

Name: _____

Relationship to Child: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Department: _____

Work Phone: _____ Work Hours: _____

Authorized to Pick Up Child: Yes _☐__

Name: _____

Relationship to Child: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Department: _____

Work Phone: _____ Work Hours: _____

Authorized to Pick Up Child: Yes _☐___

Are there any custody or restraining orders for person(s) who may attempt to pick up or have contact with the child while in care at the center? ☐ / ☐ Names: _____

Parent/Guardian Initials:

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Regina Early Childhood Center
2140 Rochester Avenue, Iowa City, IA 52245

Medical Information

Physician Name: _____

Street Address: _____

City, State, Zip: _____

Phone Number: _____

Dentist Name: _____

Street Address: _____

City, State, Zip: _____

Phone Number: _____

Known Allergies: _____

Current Medications: _____

Insurance Company: _____

Policy Holder's I.D.: _____

This Consent will be in effect for one year beginning on date signed below.

_____

Signature (Parent/Guardian) **Date**

_____

Signature (Parent/Guardian) **Date**

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2140 Rochester Avenue, Iowa City, IA 52245

Pick-Up Permission Form

I hereby give permission for my child to leave the center with the following persons named below. It is the responsibility of the parents to notify the center, in writing, of any changes.

Name: _____

Relationship: _____

Phone #(s): _____ or _____

Name: _____

Relationship: _____

Phone #(s): _____ or _____

Name: _____

Relationship: _____

Phone #(s): _____ or _____

Name: _____

Relationship: _____

Phone #(s): _____ or _____

Name of person(s) who may **not** pick up the child: _____

_____

If there is a separation or custody problem, in which Regina Staff should be aware of, please explain: _____

_____

Parent/Guardian Initials: _____ **Date: _____**

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2140 Rochester Avenue, Iowa City, IA 52245

Travel Authorization Release

I/We do _____, do not _____, give consent for _____ to participate in field trips with Regina Early Childhood Center staff. I/We do reserve the right to be notified before each field trip that involves travel out of town. I release Regina Early Childhood Center of any liability unless negligence is proven. I am aware that Regina Early Childhood Center staff may take children to parks without prior notice.

_____

Parent/Guardian Signature **Date**

Photography Release

I/We do _____, do not _____, give consent that Regina Catholic Education Center may take photographs of our child _____ and we consent that Regina may use the photographs of our child in promoting the purpose of the Center. We understand that no financial benefits from the use of the photographs are obligated to be paid to us.

_____

Parent/Guardian Signature **Date**

Confirmation of Handbook Receipt

I/We acknowledge that I have read the Regina Early Childhood Center Handbook and have access to a copy for reference on either the Regina Early Childhood website or in hard copy (by request to the Director). I agree to follow all policies outlined within the Regina Early Childhood Handbook, with special attention to those regarding parental responsibilities. The Handbook clearly outlines our program and the responsibilities of parents in order to facilitate the safety of all children in our program. I acknowledge that I have had the opportunity to ask the Director any questions regarding procedure and policy.

_____

Parent/Guardian Signature **Date**

Parent's/Guardian's Permission To Apply Sunscreen To Child

(Name of Child) _____

As the parent or guardian of the above child, I recognize that too much sunlight may increase my child's risk of getting skin cancer someday. Therefore, I give my permission for personnel at:

(Child Care Business) Regina Early Childhood Center

to apply a sunscreen product of SPF-30 or higher to my child, as specified below, when he or she will be playing outside, especially during the months of March through October and between the daily times of 10 a.m. and 4 p.m. I understand that sunscreen may be applied to exposed skin, including but not limited to the face, tops of the ears, nose and bare shoulders, arms, and legs. I have checked all applicable information regarding the type and use of sunscreen for my child:

- ❑ I do not know of any allergies my child has to sunscreen.
- ❑ Staff may use the sunscreen of their choice following the directions or recommendations printed on the bottle.
- ❑ I have provided the following brand/type of sunscreen for use on my child:

  _____
- ❑ My child is allergic to some sunscreens. Please use only the following brand(s) and type(s) of sunscreen:

  _____

  _____
- ❑ For medical or other reasons, please do not apply sunscreen to the following areas of my child's body:

  _____

Parent/Guardian full name (print): _____

Parent/Guardian signature: _____ Date: _____

Regina Catholic Education Center

Early Childhood Center Letter of Financial Agreement

2140 Rochester Ave
Iowa City, IA 52245
319-383-1017

Regina Early Childhood Center is open Monday through Friday, 7:30 am – 5:30 pm.

Our designated preschool and pre-kindergarten programming takes place from 8:30 – 11:30 am each day, Monday through Friday. Parents can choose for their student to attend preschool/pre-k only programming, or add a wrap-around care option to their program.

The wrap-around care option allows parents to drop off their students as early as 7:30 am and pick up their child no later than 5:30 pm. Preschool/pre-k only drop-off time is between 8:15 – 8:30 am and pick up is between 11:30 and 11:40 am.

Regina Early Childhood Center provides four program options. *Please mark the appropriate category and then sign below:*

Selection	Program	Monthly Tuition Rate
☐	**Preschool/Pre-k only – 3 days** 8:30 am – 11:30 am Mondays, Wednesdays, Fridays	$270
☐	**Preschool/Pre-k only – 5 days** 8:30 am – 11:30 am Monday – Friday	$480
☐	**Preschool/Pre-k + wrap-around care – 3 days** 7:30 am – 5:30 pm Mondays, Wednesdays, Fridays	$800
☐	**Preschool/Pre-k + wrap-around care – 5 days** 7:30 am – 5:30 pm Monday – Friday	$1150

PAYMENT DUE DATES: Tuition is calculated based upon your program selection and will be processed on the 10th of each month. Each family will enroll in ACH for automatic withdrawals.

No refunds are given for illness, vacation, holidays or snow days.

TERMS AND CONDITIONS: In the event of non-payment, Regina Early Childhood Center reserves the right to discontinue service. Parents will be given up to one month to make restitution. If after one month, payment has not been rendered or arrangements have not been made with the business office, the parents will be asked to withdraw their child from the Early Childhood Center.

I accept these terms of payment and agree to all conditions contained within this statement.

Printed Name **Signature** **Date**

Updated 7/12/23

CHILD & ADULT CARE FOOD PROGRAM

Your child is enrolled in a center that participates in the Child and Adult Care Food Program (CACFP). By participating in this Program, the center follows federal meal pattern requirements and receives reimbursement to assist with food costs. The CACFP requires parents to provide specific enrollment information on an annual basis. This form will be placed in center files and treated as confidential information. Complete one form for all of your children who are enrolled at the center.

June 2022

Iowa Child and Adult Care Food Program
Child Care Enrollment Form

		Times of Care		Regular Days of Care							Meals Served During Care						Ethnicity/Race*	
Last Name, First Name	Birthdate	Arrival	Departure	M	T	W	Th	F	S	S	B	AM Sn	Lu	PM Sn	D	E Sn	Ethnicity	Race

*Ethnicity (Select one and enter in the chart above): H=Hispanic or Latino or N=Not Hispanic or Latino
*Race (Select one or more and enter in the chart above): W=White, B=Black or African American, I=American Indian or Alaska Native, A=Asian, and P=Native Hawaiian or Other Pacific Islander This information is requested by the Federal Government in order to monitor compliance with Civil Rights law. You are not required to furnish this information, but are encouraged to do so. The law requires that organizations may not discriminate on the basis of this information nor on whether you choose to furnish it.

Infants only (0 to 12 months): ❑ I am not enrolling an infant (skip this section)

As a participant in a USDA Child Nutrition Program, our center offers meals to children of all ages; you are not required to provide infant food or formula. Infant feeding is based on Academy of Pediatrics nutrition guidelines. Infant foods served are appropriate for the age and developmental readiness of your infant. Mark (X) to indicate your choice(s) below:

❑ I will provide breastmilk for my infant. ❑ Yes ❑ No ***If infant is still hungry and no breastmilk is available, list what to feed*** _____

❑ I would like to breastfeed on site, if this option is available[1]. ❑ Yes ❑ No If yes, time(s) _____

❑ I will provide formula for my infant. Name of formula (must be iron-fortified and manufactured in the USA): _____

❑ I accept the center's formula for my infant. Name of iron-fortified formula: _____

❑ I will submit a Diet Modification Request Form for non-reimbursable formula. Name of formula: _____

❑ I accept the center's solid foods (appropriately textured) to be served to my infant as s/he is ready for them, and after I have discussed it with the caregiver.

❑ I will provide solid foods for my infant[2]. The center may supplement with additional solid foods when my infant needs them: ❑ Yes ❑ No

Parent Signature _____ Date: _____

Parent Signature _____ Date: _____ (Make any needed changes above, sign and date)

Parent Signature _____ Date: _____ (Make any needed changes above, sign and date)

[1]Ask your center if you can breastfeed on-site.

[2]The parent may provide no more than one required meal component in order for the center to claim reimbursement for the meal. DHS licensed centers must follow CACFP infant meal pattern requirements regardless of who supplies the food. Your center can provide a copy of the CACFP infant meal pattern and a list of reimbursable foods upon request.

This institution is an equal opportunity provider.

Automated Payment Processing

Procare SOLUTIONS

Safe. Convenient. Easy.

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT

I (we) hereby authorize (business name) Regina Catholic Education Center to initiate debit entries to my (our) checking or savings account, indicated below (Section A). To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments.

SECTION A (Bank Account)

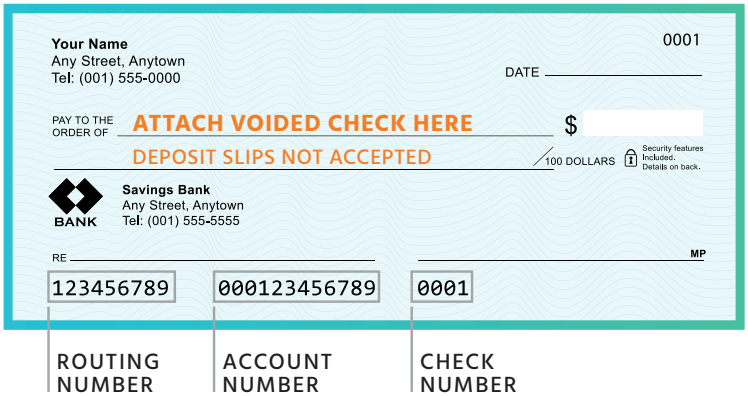
Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____



FOR OFFICIAL USE ONLY

Date Received

Employee Signature

800.338.3884 • procaresoftware.com

Iowa Department of Public Health
Certificate of Immunization

Name Last: _____ First: _____ Middle: _____ Date of Birth: _____

Parent/Guardian: _____ Address: _____ Phone: _____

I certify that the above named applicant has a record of age-appropriate immunizations that meet the requirement for licensed child care or school enrollment.

Signature: _____ Date: _____

Physician, Physician Assistant, Nurse, or Certified Medical Assistant

A representative of the local Board of Health or Iowa Department of Public Health may review this certificate for survey purposes.

	Vaccine	Date Given	Doctor / Clinic / Source
Diphtheria, Tetanus, Pertussis DTaP/DTP/DT/ Td/Tdap			
Polio IPV/OPV			
Measles, Mumps, Rubella MMR			
***Haemophilus influenzae* type b** Hib			
Hepatitis B			

	Vaccine	Date Given	Doctor / Clinic / Source
Varicella Chicken Pox *If applicant has a history of natural disease write "Immune to Varicella"*			
Pneumococcal PCV/PPSV			
Meningococcal MCV/MPSV/ Mening B			
Hepatitis A			
Rotavirus			
Human Papilloma Virus HPV			
Other			

January 2013

IMMUNIZATION REQUIREMENTS

Applicants enrolled or attempting to enroll shall have received the following vaccines in accordance with the doses and age requirements listed below. If, at any time, the age of the child is between the listed ages, the child must have received the number of doses in the "Total Doses Required" column.

Institution	Age	Vaccine	Total Doses Required
Licensed Child Care Center	Less than 4 months of age	This is not a recommended administration schedule, but contains the minimum requirements for participation in licensed child care. **Routine vaccination begins at 2 months of age.**	
	4 months through 5 months of age	Diphtheria/Tetanus/Pertussis	1 dose
		Polio	1 dose
		haemophilus influenzae type B	1 dose
		Pneumococcal	1 dose
	6 months through 11 months of age	Diphtheria/Tetanus/Pertussis	2 doses
		Polio	2 doses
		haemophilus influenzae type B	2 doses
		Pneumococcal	2 doses
	12 months through 18 months of age	Diphtheria/Tetanus/Pertussis	3 doses
		Polio	2 doses
		haemophilus influenzae type B	2 doses if the applicant received 1 dose before 15 months of age; or 1 dose if received when the applicant is 15 months of age or older.
		Pneumococcal	3 doses if the applicant received 1 or 2 doses before 12 months of age; or 2 doses if the applicant has not received any previous doses or has received 1 dose on or after 12 months of age.
	19 months through 23 months of age	Diphtheria/Tetanus/Pertussis	4 doses
		Polio	3 doses
		haemophilus influenzae type B	3 doses, with the final dose in the series received on or after 12 months of age; or 2 doses if only 1 dose received before 15 months of age; or 1 dose if received when the applicant is 15 months of age or older.
		Pneumococcal	4 doses if the applicant received 3 doses before 12 months of age; or 3 doses if the applicant received 1 or 2 doses before 12 months of age; or 2 doses if the applicant has not received any previous doses or has received 1 dose on or after 12 months of age.
		Measles/Rubella[1]	1 dose of measles/rubella-containing vaccine received on or after 12 months of age; or the applicant demonstrates a positive antibody test for measles and rubella from a U.S. laboratory.
		Varicella	1 dose received on or after 12 months of age, unless the applicant has a reliable history of natural disease.
	24 months of age and older	Diphtheria/Tetanus/Pertussis	4 doses
		Polio	3 doses
		haemophilus influenzae type B	3 doses, with the final dose in the series received on or after 12 months of age; or 2 doses if only 1 dose received before 15 months of age; or 1 dose if received when the applicant is 15 months of age or older. **Hib vaccine is not required for persons 60 months of age or older.**
		Pneumococcal	4 doses if the applicant received 3 doses before 12 months of age; or 3 doses if the applicant received 2 doses before 24 months of age; or 2 doses if the applicant received 1 dose before 24 months of age; or 1 dose if the applicant did not receive any doses before 24 months of age. **Pneumococcal vaccine is not required for persons 60 months of age or older.**
		Measles/Rubella[1]	1 dose of measles/rubella-containing vaccine received on or after 12 months of age; or the applicant demonstrates a positive antibody test for measles and rubella from a U.S. laboratory.
		Varicella	1 dose received on or after 12 months of age, unless the applicant has had a reliable history of natural disease.
Elementary or Secondary School (K-12)	4 years of age and older	Diphtheria/Tetanus/ Pertussis[4, 5]	3 doses, with at least 1 dose of diphtheria/tetanus/pertussis-containing vaccine received on or after 4 years of age if the applicant was born on or before September 15, 2000 [2]; or 4 doses, with at least 1 dose of diphtheria/tetanus/pertussis-containing vaccine received on or after 4 years of age if the applicant was born after September 15, 2000, but on or before September 15, 2003[2]; or 5 doses with at least 1 dose of diphtheria/tetanus/pertussis-containing vaccine received on or after 4 years of age if the applicant was born after September 15, 2003 [2, 3];and 1 time dose of tetanus/diphtheria/acellular pertussis-containing vaccine (Tdap) for the applicant in grades 7 and above, if born after September 15, 2000; regardless of the interval since the last tetanus/diphtheria-containing vaccine.
		Polio	3 doses, with at least 1 dose received on or after 4 years of age if the applicant was born on or before September 15, 2003[7] ; or 4 doses, with at least 1 dose received on or after 4 years of age if the applicant was born after September 15, 2003[6] **Polio vaccine is not required for persons 18 years of age or older.**
		Measles/Rubella[1]	2 doses of measles/rubella-containing vaccine; the first dose shall have been received on or after 12 months of age; the second dose shall have been received no less than 28 days after the first dose; or the applicant demonstrates a positive antibody test for measles and rubella from a U.S. laboratory.
		Hepatitis B	3 doses
		Varicella	1 dose received on or after 12 months of age if the applicant was born on or after September 15, 1997, but born on or before September 15, 2003, unless the applicant has had a reliable history of natural disease; or 2 doses received on or after 12 months of age if the applicant was born after September 15, 2003, unless the applicant has a reliable history of natural disease.[8]
		Meningococcal (A, C, W, Y)	1 dose of meningococcal vaccine received on or after 10 years of age for the applicant in grades 7 and above, if born after September 15, 2004; and 2 doses of meningococcal vaccines for the applicant in grade 12, if born after September 15, 1999; or 1 dose if received when the applicant is 16 years of age or older.

1 Mumps vaccine may be included in measles/rubella-containing vaccine.

2 DTaP is not indicated for persons 7 years of age or older, therefore, a tetanus and diphtheria-containing vaccine should be used.

3 The 5th dose of DTaP is not necessary if the 4th dose was administered on or after 4 years of age.

4 Applicants 7 through 18 years of age who received their 1st dose of diphtheria/tetanus/pertussis-containing vaccine before 12 months of age should receive a total of 4 doses, with one of those doses administered on or after 4 years of age.

5 Applicants 7 through 18 years of age who received their 1st dose of diphtheria/tetanus/pertussis-containing vaccine at 12 months of age or older should receive a total of 3 doses, with one of those doses administered on or after 4 years of age.

6 If an applicant received an all-inactivated poliovirus (IPV) or all-oral poliovirus (OPV) series, a 4th dose is not necessary if the 3rd dose was administered on or after 4 years of age.

7 If both OPV and IPV were administered as part of the series, a total of 4 doses are required.

8 Administer 2 doses of varicella vaccine, at least 3 months apart, to applicants less than 13 years of age. Do not repeat the 2nd dose if administered 28 days or greater from the 1st dose. Administer 2 doses of varicella vaccine to applicants 13 years of age or older at least 4 weeks apart. The minimum interval between the 1st and 2nd dose of varicella for an applicant 13 years of age or older is 28 days.